Title: Running Morbidity and Mortality Rounds in Equine Practice.

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Andy Fiske-Jackson: Hello and welcome to this RCVS Knowledge Webinar on morbidity and mortality rounds. My name's Andy Fiske-Jackson. I'm an associate professor of equine surgery at Royal Veterinary College and also an RCVS and European specialist in equine surgery.

I feel very fortunate to talk to you about morbidity and mortality rounds. A little bit of background from my perspective in the first instance, we've been doing morbidity and mortality rounds at the Royal Veterinary College, which is where I work for a decade and a little bit. I have to say initially, we're not very good at them and this has evolved though and we've got a lot better and certainly I've now understood and really taken advantage of all the benefits that morbidity and mortality rounds give us and also how they integrate with clinical governance as a whole. I'll give you some examples of how we use it and some of my hints and tips of how I think you can get the most out of it.

Firstly, the RCVS Knowledge mission which provides this webinar is to advance the quality of veterinary care for the benefit of animals, the public and society. And champions use of evidence-based approach to veterinary medicine inspire a culture of continuous quality improvement in practice. These resources are available freely and are hugely valuable. I'll reiterate that during and at the end of this webinar. They're a charity partner of the RCVS themselves and the website you can see during the slides at the bottom.

So let's make a start. So why do M&M rounds? Well, first and foremost, we have a professional responsibility to do them. The RCVS code of professional conduct clearly states that any critical event, now this could be a significant event or simply a morbidity or of course the mortality, surgical complications, whatever it might be. No-blame meeting should be held actually as soon as possible after the incident. This can be discussed elsewhere in terms of something like a hot debrief but then a more thorough discussion of the event should take place.

We'll look at what cases should be involved in the next few slides. And then we want to communicate changes in procedure to the whole practice team. That's important. It's no good if you simply discuss it amongst yourselves and then don't tell anyone. That problem will simply arise again. And so this discussion has to be had as part of a team where everyone can contribute. The code of conduct also dictates that regular clinical discussion meetings for the practice team should be performed. We should record the minutes, which is then of course disseminated, and then reviewing the action points at future meetings as well to look back. This feeds into clinical audit and clinical governance as a whole.

All clinical staff should be encouraged to participate and input items onto the agenda. They should follow up any of those clinical issues arising from clinical discussion meetings. This could result in changes as a result of clinical discussion meetings, and they should be monitored as well to make sure they're effective. That's very much what clinical audit is about. So we do have an obligation, but of course that really isn't what it should be about. We have an obligation, it should be done of course, but we really should understand the benefits of this.

Over the years, I honestly can feel that we can gain such benefit of these rounds. Actually, oddly it can be rather therapeutic as a clinician if you make an error to better discuss it within your team, almost get it off your chest but also figure out that actually there are other factors contributing to the mistake that was made or the morbidity that happened or even the mortality and you can learn from them to move forward.

So which cases should be in M&M rounds? While all deaths of course should be discussed, sometimes these deaths will be euthanasia on financial grounds and in reality many of those won't need significant discussion. If I work in an equine industry, say if a horse needs colic surgery, the owner declines surgery on financial grounds and the horse is euthanized, then in reality there's not a huge amount to discuss there. Yes, you could discuss your pricing structure.

What's often beyond the remit of M&M rounds? Never events from surgery sites, safety incidents resulting in moderate harm, patients who was discharged was delayed due to complications, unplanned patient readmissions, any patient was returned to theater within the same admission, severe intraoperative complications and near misses. So now these are things which sometimes might go under the radar, things that, for example, horse goes back to surgery. You can think, well, okay that just happened and oddly you won't think to report it.

I think the key thing with these is have a very easy way of reporting. Now VetSafe is an option here which is part of the VDS and this is an opportunity to just simply report online and it's got a very neat reporting system within it. We ourselves don't use VetSafe for various reasons. It's a good database but whatever the database you have, it needs to be very easy to report. It's no good if it's arduous because it simply won't happen. It's useful to be honest if it could be something accessible as an app online, and also whose responsibility it is to report it. Okay? So they all need to report into a central database so that they can even discuss. When we do monthly meetings, we find that works for us. It may be that you can get away with two monthly meetings.

I wouldn't go any longer than that because it gets difficult to remember all the details of cases. And it's also, you need enough time, you need more time than you would think to discuss matters. Actually, we usually run out of time and I'll come back to that in a moment and what ways you've got around that. But anything really that obviously it dies but has a morbidity associated with it where essentially the case didn't go to plan, it's something that should be discussed.

What about the structure? Of course, you need someone to lead the meeting and a moderator that is, they should have authority. Of course, you need to have someone who is respected in the practice. That might be a partner within the practice, clinical director or someone who's relatively remote. In my experience, it's better to have someone who isn't likely to be invested in many of the cases.

I'm in academic institution, we're fortunate to have academics who aren't necessarily involved clinically and that could be quite a useful trait. However, they need to have a knowledge of clinical procedures in order to fairly contribute. They must foster an open, collaborative and supportive discussion, and they shouldn't minimize or indeed magnify errors. They must be very balanced. They must have of course a knowledge of the M&M rounds format.

And then we'll have a presenter. These are people who present the cases and of course they'll be whoever's case it is. So it'll be the same person and you'll need the attendees and that we would encourage everyone to attend. You certainly need all clinicians to attend, but we encourage, have as many people attend as possible. Now we run the meetings in person but they are also online as well through Zoom or Teams or similar. That of course enables contributions for those who are not on site or perhaps working in reception and can't leave reception of course. These people need to feel involved from top to bottom to contribute to

the case. And then you need a root cause analysis to undertake a look at that in a moment. And then follow up and potentially clinical audit.

I've put in some examples here. We don't need to look through all of them, but these are just some examples that might occur in our hospital. So here, we have one where we get a catheter bag detachment from the top left here, no adverse effects seen, body [inaudible 00:09:50] and physical exam were normal. We've got another patient here just below that broke its subpalpebral lavage system and a replacement was routinely placed. And then I've got the upper eye became swollen and the horse was put on antibiotics and pain relief and actually did fine. But it is ultimately the morbidity that needs to be discussed.

Here we've got another one that has an oro-sinus fistula on extraction of 209 tooth, treatment of sinusopathy via laser and prolonged the hospital stay. But ultimately, the outcome was fine. So see some examples here where essentially things didn't go to plan and these are not horses that died. They simply didn't go exactly as they would have gone. And not all cases require discussion and it'd be up to the moderator to lead it perhaps to decide which ones are going to be discussed. We would compile the whole list of morbidity and mortalities. But we can advance now sent to the moderator and then for us they're sent back, they're sent to everyone as well. And people put forward to the moderator if they feel one particular case needs to be discussed. That might be they have a particular interest in this case or they have something they feel really should be discussed for the greater good.

Now the moderator will then ultimately have a decision about what is discussed. But as I stressed, you can give yourself too much to cover. My meetings last for an hour. I don't think being any longer than that is beneficial to hold people's attention. And if you have too much to discuss, maybe you should increase the frequency of your meetings but also perhaps be more discerning about what you do discuss. You need to monitor for trends, and we'll come to that in due course. There needs to be trust within M&M rounds. There's no good having discussions if people aren't being open and honest about what has gone on.

To be open and honest, you need to trust your colleagues and know that they care about you and also they are competent. If you ask for help, they can do what they promise. In other words, they are being genuine about their expertise and their willingness to engage in the process with you. You need to understand the structure. No one in M&M rounds are trying to achieve. It's about education, it's about learning from our mistakes. It's not at all about trying to find out who is responsible and retribution. We'll come to that in a minute. And it certainly is not just a tick box exercise, not just satisfy RCVS requirement or even our award scheme requirements.

You need to see it as actually a learning exercise. And I promise you, you will see the benefits if you discuss these and then these can feed into clinical audits, you can change them, stop these mistakes from happening in the first place and all team team members should be able to attend, I said to you before. There's various different models out there and guidelines as to how you might want to run M&M rounds and you really must run it as you see fit.

In the first instance, don't make it complicated. Simply have those cases and discuss them. I'll give you some guidelines moving forward. Case selection, as I said, you need a reporting system. For example, VetSafe and as I said, you decide what to discuss because discussing everything is unlikely to be (a) beneficial or (b) practical, not always the weird cases. The very weird cases may just be so outlandish. They're not actually going to be beneficial to get a move forward with any significant benefits and guidelines and things to take with you.

Really if you're looking at care delivery problems, what went wrong during the care of this horse or small animal, cow, sheep, whatever it might have been that resulted in the unexpected outcome. Was it an error or omission by a staff member? Identify what active pain they contributed directly or indirectly to the result. And that's come on to the [inaudible 00:14:32] Pam Mosedale very much an advocate of the five why's. Why? Why did this happen? Why did that happen? And it really just helped to keep asking that.

You're looking for the root cause analysis as well and that's what this is about. You may want to identify the human error because sometimes people do make mistakes and it's unlike with a cognitive issue. Hopefully well, hopefully not. It's more likely to be just a straightforward error. But why did that happen? Are they tired? Do they have too many things going on or their attention distracted by something else going on? There are lots of things that you can look at on that front, and the system fact which contributed.

Is there something about the way things were booked in, the way that the theater table was set up? Things that ultimately are parts of the system which goes on every single day, this is how things are done. Things can change, things could be better if we look at every time we do this, this happens. It could be quite a simple change. Just because they've always done it like this doesn't mean to say that it always has to be done like that.

So we're looking at patients factors, individual staff factors, the task, communication, the team, social interactions between the team, equipment available within your practice and resources, environmental and working conditions and perhaps a bigger picture of the strategic and organizational practice. Really this boils down to four areas: people, process,

environment and equipment. When you're discussing these, you can look at them under these particular headings.

If you want to identify the problem as part of your structured case analysis, discuss possible major causes, and then go on to discuss each major ethically as you see here. It can be broken down into further contributing factors as well. Who made the mistake but why did it happen? As I said before, the five why's. We're not looking to blame the individual person. Let's say person makes a mistake in theatre, they make a surgical error and on the face of it can seem as simple as that.

The surgeon made an error, that's the end of it. But why did that surgeon make an error? Was it that they are being distracted by receptionist that was phoning into theatre asking for when a client's going to be phoned back, for example, someone asking a surgeon a question. They were distracted. Well, why was that? Well, no one had told the receptionist that the surgeon was in theatre. Why was that? Well, the receptionist had just come in and there's no way of making that communication evidence.

And so you can start saying, well that's fine. We can change this by relaying to reception that so-and-so is in theatre and anyone who rings, anything needs to go on, you have to wait when that person's out of theatre. So it's not as simple as a surgeon necessarily making a mistake. In order to get to the root cause, you need to ask those particular questions of why and then you can start to improve outcomes considerably. That's just one example, but it's something which I think hopefully illustrates the point.

Things that are put into VetSafe have litigation privilege. It can't be accessed by subject access request, and so it is a safe environment to put these. Then you may want to do an in-depth investigation. SBAR, situation, background, assessment analysis, recommendation can be very in-depth but also it can just be a simple way of presenting the case. This isn't a wholesale presentation of every aspect of the case. We're not looking to understand all the clinical particulars of the case, but we want to understand the salient points. So it's important when people present that they see this and we're looking for it to understand as much background as we need to understand the morbidity or mortality without going into too much detail. You'd lose interest or lose the audience through concentration. You have the reason for admission, the procedure that was carried out and the adverse outcome.

Okay? And we talk about this as I said that there may be some relevant clinical information and then what happened and why. Sequence of events is important because that may outline and highlight why something happened. And then we get to the root cause analysis. We talk

about people, the process, environment, and the equipment. And then we might want to review the literature and this would be part of more in-depth review. We would use SBAR when we have certain conditions where we feel perhaps it requires a more in-depth investigation or perhaps where the knowledge of the audience isn't sufficient to answer the question. This next point is important, the evidence where someone takes on board. So actually we'll review the evidence and so we can make an informed decision on how we're going to move forward with recommendations, how could the problem be preventive or better managed and what are the learning points.

I'll give you two examples of an SBAR that occurred in our hospital and this was a colic exploratory celiotomy. So abdominal surgery was performed and the owner was unaware of the limitations for mortality claim, and horse was ultimately euthanized upon the request of the owner, and the owner complained when she was unable to get a mortality insurance claim afterwards. This horse have acute colic is the background clinical information, but acute colic, the reason for the intervention, well we had identification of distended small intestine, which is usually a surgical lesion.

And when we went in surgically we had 15 to 20 feet small intestine identified for resection and anastomosis. So you see that clinical details enough, we know we're not getting all the biochemical parameters, all the heart rate, respiratory, we're just getting this was a surgical problem and the horse needed a resection and anastomosis of small intestine. The prognosis 60 to 80% of survival was given but the owner elected euthanasia. But because her insurance for fees medical only covered her up to 2,000 pounds, the owner contacted the RVC, approximately one month following euthanasia to obtain confirmation that the horse was euthanized under BVA guidelines. And as explained, unfortunately, no BVA guidelines were not met for that euthanasia.

The error analysis we did not discuss the impact of the decision of the owners on mortality claim as they're unaware of mortality insurance, that the owners have limited knowledge about this aspect. So it was our responsibility to inform the owner that prior to euthanasia that this would not be covered under mortality claim. You can imagine this is a emotive time and maybe difficult to have this discussion but certainly this was where the complaint came.

So the human factors as well assumption was made and system factor as well is not detailed on the record but the mortality insurance is in place. So we didn't actually have that part as a information available in patient record and in the history that was taken prior to colic surgery. Obviously, the patient factors were not relevant in this situation. So if we look at the BVA guidelines where we review the evidence, we look at the BVA guidelines to just reaffirm

to everyone what contributes to the BVA guidelines saying this warrants humane destruction.

Well, this is important. We've got to relieve incurable and excessive pain, that no other options of treatment are available. With this pony, it was clear that there was a treatment option available. A chronic illness or lameness. Well, instantly this is not relevant in this case. It wasn't a chronic illness or lameness and it wasn't such that the horse posed a significant pain for its handler or members of the general public as a result of this illness. So this is the horse and the GA. So on review of the literature, we confirm the horse did not fulfill the requirements with humane destruction.

So what could we learn from this? Well, we felt we should have asked the owner about mortality insurance prior to euthanasia. This conversation is probably better had prior to surgery although at some point it has to be had. And if it's when the owner was called in the middle of surgery to inform her of the prognosis, then prior to making the decision for euthanasia, it should have been relayed to the owner that if she has mortality insurance that does not fulfill BVA guidelines. Those BVA guidelines should obviously be available to explain to the owner in black and white.

This is actually quite a common problem. It's not the first time it would've come up. The learning points, always ensure the owners understand the implications of euthanasia. So explain and now have a laminated checklist in theatre with those BVA guidelines in place that we can relay very easily word for word or to remind the person who's making the call but also to remind them to just have that discussion however difficult it may be because it was after all [inaudible 00:25:33] made going back and forth.

Second example, slightly more in-depth is again a colic. Okay. The procedure was a colic assessment and this horse had gastroscopy and duodenal biopsies, repeated abdominal centesis. The adverse event outcome or complication was unfortunately suffered a ruptured cecum secondary to a caecal impaction and the horse was euthanized. Well, let's look at this in more depth. So history, this horse has had previous colic investigations for failure to weight gain.

The diagnosis and lab results had a pelvic flexure impaction on presentation, which based on rectal pap patient had [inaudible 00:26:20], had a peritonitis based on peritoneal fluid analysis, and that two had resolved. Had possible inflammatory bowel disease based on duodenal biopsies which had been taken due to multiple colic episodes and that had not yet been addressed. Another way of treatment had not yet been taken for that. On day nine of

hospitalization for this quite a long period of hospitalization due to the colic, persistent colic, but had she got better.

Actually, the horse is due to get home that day, and had developed these mild colic signs and had repeated colic requiring the administration of analgesics. This was on day nine. On day 11, surgical exploration eventually was undertaken and unfortunately a ruptured cecum as a result of an impaction was found and the horse was euthanized due to hopeless prognosis. So we also wanted to understand what went well, what could we learn from this case? Well, the error analysis was failure to recognize the treatment of cecum impaction in a timely fashion. The root cause analysis, well, the financial situation of the owner delayed the clinician's decision for surgery by 12 hours. So we were recommending surgery prior to the time that the horse went to surgery by at least 12 hours.

There's a history of possible inflammatory bowel disease which clouded the clinical judgment. So we have other reasons for this horse's colic. We had a persistent colic, we had duodenal biopsy which suggested it had inflammatory bowel disease, and we had obviously made the error in feeling that that is the cause of the horse's colic. System factors, well, there was more than one clinician involved with found two weekends in fact. That obviously made... There was a break in communication. We do have handover communications but of course nothing is quite like being with the case during the week.

The patient factors. Well, the patient was not an easy horse to rectal exam without prior sedation and therefore, we always would weigh up the value of a rectal sedation of the regular exam due to the sedation of bulk and reducing gut movement. So we want to review the literature in terms of recognizing caecal impactions and also treating caecal impactions. Recognizing caecal impactions or the risk factors of older horses, general anaesthesia, orthopaedic surgery. The meantime from orthopaedic surgery to caecal impaction, it's three and a half day.

Colic surgery itself, meantime from colic surgery to getting a secondary caecal impaction after surgery is seven and a half days. Ocular condition is a risk factor. Orthopaedic surgery plus NSAIDs involved [inaudible 00:29:28] one six months old, Mares after foaling and innate gestation. All these are risk factors for caecal impaction. But one third are diagnosed in rectal exam by admitting veterinarian. These are not easy to palpate sometimes, so they can be missed 82% on rectal exam in the referral hospital, but not a hundred percent that they can be missed. One in five are missed.

Treatment of caecal impaction. Well, unfortunately around, depending on the literature, which papers you read, 25 to 57% will rupture. That's important to relay once it's been diagnosed to relay to the owner. Medical management, 80% are discharge from hospital. Surgical management, 71% are discharged just by discharge from hospital. They have different options of medical and surgical management.

The recommendations moving forward. Vigilance of course is required. Due attention to the fact that a caecal impaction can be secondary to those things which we saw before. Orthopaedic surgery, colic surgery, ocular emergency, et cetera. And there's awareness of those should be communicated to the team or the owner. So the team are aware to look out for them and the owner is aware that this particular condition can result in an impaction. And as a consequence, now with every consent form we write down the risk of colic as possible complication.

Normal physical exam findings and [inaudible 00:31:03] rectal exam do not rule out a significant intestinal lesion including a caecal impaction. We should also have a patient record system to alert the clinician of faecal output below two droppings between 8:00 PM and 8:00 AM. You may wonder why not during the day. We also can be out in the clinic having things done during the day. But overnight but in a stable we should be alerted when the faecal output is below two droppings overnight. That maybe it's being starved and it's fine, we got a simple explanation for that. But an alert, we have an electronic system now which will alert the clinician when that happens.

These are signs that will help to identify caecal impaction sooner. Of course, an early celiotomy as a diagnostic or therapeutic procedure may be warranted. So a list of recommendations based on our SBAR, I mean they communicate these back through the team and make the changes. And of course it may be that we would want to audit that and see if it reduces our incidents of caecal impactions and no contact in the moment. These are important as well. These are moving annual totals and you probably will may remember these through the COVID pandemic when you're looking for an average rather than just taking each day.

And so this is rolling yearly sum. So you take an average probably each, you take the 12 months of the year preceding where you actually are at the moment and you average the number per month. And then the following month, you obviously add on the new month and take off the month or the start of that period and take the average again. So it helps account those blips, those elevated highs or elevated lows and you get them more genuine appreciation.

So these are all the morbidities in the different subject areas we have that we use. So surgical complications, it's fine, I should see these reducing. If we look across here, wound infections, we see a spike up here, and diagnostic imaging, diagnostic imaging we got flat here. But you can see generally speaking, we're getting some good reductions. Now you might think this is wonderful, but of course you must make sure that morbidities are being reported effectively. This will only work if it's an effective reporting system. But by looking at moving annual totals, we're able to look at the average which is more relevant than individual spikes. Of course, this may prompt an audit for example of in this case wound infections where we see a spike, where we look at the instance of wound infections and see what could be going on, are they being cultured, et cetera, et cetera.

That's important to understand second victim syndrome. I'm very big on this in respect to making clinical governance like clinical morbidity or mortality work. The first victim of course is the patient. But any of us who are better to understand how you feel when as the vet, if you are the person who's made the error or the morbidity is your patient responsible. And there's the blame culture, which you feel. The clinician is traumatized by the event and it depends on different clinicians and experience how traumatized you are. If it's a new graduate, they'll probably feel awful thinking, "Well, if only someone is more experiences were involved, this wouldn't have happened." This may not be the case. Remember we're talking about systems rather than individuals. But inevitably then the nurse involved will feel like they felt the patient or the nurse involved will feel like they felt that patient.

My second guess, their skills and knowledge base and even their career choice and they have lots of emotional feelings, anger and guilt, psychological distress and may have difficulty sleeping and crisis and confidence. We need to understand that when we are having these discussions and when morbidities happen or mortalities of course. The second victim has got some work done by Robin White and co in the States. The second victim's perceptions of the current just culture. Just culture, including what victims want to understand that it's a just culture, it's a fair culture when it comes to morbidities and the fear of repercussions of reporting medical error acts as a barrier.

So if you think that it's going to be retribution involved, you're less likely to report it due to try and keep your job. But ultimately you are internalizing everything and not discussing it. As I said to you before, discussing it I believe, I find is quite therapeutic. You need a supportive and safety leadership, which is essential to reduce fear in error reporting. Improve education on adverse event reporting is important 'cause people need to understand that if they do report an event there's something productive comes out of it. There's no good if you think, "Well, nothing ever happens. If I report this, we'll talk about it, then nothing

happens." And the others who see that, well, this keeps coming up, we never seem to make any changes.

So you need to implement changes. Maybe the changes don't work, and that's part of auditing. They say, "Well, we made this change, it doesn't work, it hasn't made any difference." Fine. Well, we know that and we move on, we try something else and develop a positive feedback when an adverse events are reported. But just culture is quite hard to truly achieve, the proverbial can of worms. There has to be movement towards getting it.

I've just put this slide, we have a restorative versus retributive just culture. And what we don't want is retributive. So retributive is basically what rule has been broken? How bad does it be? What's the consequences be? We're trying to find someone to blame and it plays out being the offender and the employer acts like a clash and excludes the voices of everyone else. Everyone else shrinks back while this is going on. It becomes just a very one dimensional where things are going to be missed as I'm making to prove. Reasons for morbidities will be missed. Obviously, it'll be linked with hiding incidents 'cause no one wants to go through that and an unwillingness to report and learn.

As I said, it does not identify systemic contribution to the incident and therefore it'll just happen again. Worst case scenario, if someone makes a mistake, they get fired and there's something about the system which is the problem. The next person comes in, systems are same, same mistakes happened. You can see they have the chain event. Far better to have restorative culture. All parties discuss collaboratively and decide on what needs to be done. Who is hurt? We think about the second victim. What do they need and how will they move forward? By giving an honest account, contribute to learning and see a positive outcome to the event. If we all see that, we all think, well, this keeps happening. This happened actually to this horse. It's got a catheter complication, it's got a wound, it broke down again. And then think, well, actually this is a morbidity. We need to discuss this. And we start putting them in. And with the moving annual photos, we may see some trends, which generates an audit as well.

And so we need to see when we do have M&M rounds, that we have restorative culture, supportive culture to encourage people to come forward with problems. As I said, I find it... I mean I have cases that come into morbidity and mortality rounds. Of course I do just like anyone else, and I find it therapeutic just to [inaudible 00:39:01] say, I did this, but we have the people I find come along and say, "Yes, look, this happens and this happens to me as well." Actually, you generate a really, really fruitful discussion because it'll be pretty much guaranteed that if it happens to you, it also happens to other people as well.

So what we want to happen with M&M rounds? Well, we want to make changes to clinical practice, positive changes based on those areas. We want to stop the errors from happening as far as we can, never completely eliminate them, but trying to make changes to systems that stop the errors. All outcomes from morbidity and mortality rounds report to clinical governance meetings if you have them, and I urge you to have those because they all bring in other factors like near misses and so forth. It may prompt the clinical audit. If we find, look, we're getting a lot of these, we need to actually scratch the surface a little bit more, make a change, re-audit. Okay? And they feed directly into auditing.

Provide a just restorative culture, as I mentioned, where honesty and upfrontness encourages an open collaborative approach where people feel like you can discuss these problems. They don't take them home with them and have sleepless nights thinking about them. They think, you know what? I had a really good discussion about this, I feel a lot better about it now. That's something you really should be encouraging in our profession. And of course it maintains the public trust in the profession. They want to understand when mistakes happen that they are discussed.

And I find that when discussing complaints with others saying, look, we have discussed this as a group, we've made changes to. And so just as anyone wants to see it, no one wants their horse or small animal or whatever it might be to suffer morbidity. But if they feel, and this has been proven with evidence that quite simply it won't happen to someone else, something has been changed as a consequence, that allays a lot of clients' worries and concerns and anger, knowing that a change has been made as a consequence and we've listened and learned. And that's really important. So it maintains a public trust in the profession.

I hope that helps with the approach to mobility and mortality rounds. Put some references in there, some great resources on the RCVS Knowledge website. Honestly, it's a fantastic resource coming at someone completely independent from the RCVS Knowledge team. They're a fantastic team and Pam Mosedale herself is a huge authority on this subject. But all I can say, get that reporting in and have some discussions about some cases. I promise you it'll evolve into a very, very fruitful and satisfying experience and it'll improve outcomes ultimately for your patients in your practice. Thank you very much for listening.

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